PAYMENT REFORM PRIMER

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Introduction

If the adage, "You get what you pay for", holds true then the United States needs to significantly reform how it pays for health care. Put simply, we spend more than any other developed nation but we get less for it. We leave 47 million Americans without health coverage and do not get better quality or health outcomes for all our spending. According to a recent McKinsey Global report, Accounting for the Cost of US Healthcare: A New Look at Why Americans Spend More, the United States spends $643 billion a year more than we need to. McKinsey documents those costs, noting that supply drives demand and that the United States has:

- an over-supply of out-patient services;
- we conduct more surgery without better outcomes;
- we have three to six times more scanners than Germany;
- physicians see more patients and are paid more even though we have the same distribution of generalists to specialists;
- we have fewer in-patient beds but the cost per bed is four times other nations;
- we use 10% fewer prescriptions but pay 50% more for them;
- while the US spends twice on public health what other developed nations do, we do not spend it adequately on prevention.

Here in Maine the current State Health Plan called for a study of cost drivers. That study, conducted by Dirigo Health Agency's Maine Quality Forum , using data from the Maine Health Data Organization and through a contract with Health Dialog , documented $300 - $400 million that could be saved in Maine if we reduced unnecessary variation in care. Another study conducted by the Muskie School showed that Maine has a 30% higher use of emergency department use. These studies are validating what McKinsey found for the nation – that there are inefficiencies in our health care delivery system that are creating avoidable costs.

A growing consensus concludes that how we pay for health care is a reason for our high cost system. Our traditionally fee-for-service approach to payment creates financial incentives to do more and provide more costly services but does not provide adequate incentives to manage care or improve the efficiency and quality of care and keep people healthy. As is frequently noted, preventive and primary care is not well funded in our current payment structures. Rather, the payment structure rewards volume not value. Research indicates that more spending and more supply of services does not result in better outcomes and can often produce worse outcomes. Redirecting how we pay for care, then, has great promise in improving care and reducing costs but requires significant redirection of the status quo.

An early example of payment reform is the movement to Patient Centered Medical Homes. This initiative creates teams comprising primary care providers and other health care professionals who are accountable for primary and preventive care and pay them enhanced fees to do so. Increasingly, payment reform has been structured as a means to bundle payments or establish global fees, particularly for people with chronic disease, as a way to encourage prevention and restructure how care is delivered to replace volume

incentives with value incentives – identifying patient needs early, providing appropriate interventions and maintaining health while reducing redundancy and unnecessary services. The concept of bundled or global payments is not new. Kaiser Permanente, Mayo Clinic and other models, described later in the paper, have integrated physician practices and delivery structures. Managed care was an early attempt to restructure incentives but capitated managed care has not been without controversy. Consumers resisted what they perceived to be gate keeping based on cost not quality; employers, in search of lower costs, moved from plan to plan, challenging the concept of managed care to manage population health over a long period of time and thereby achieve savings. And, the movement failed to address the underlying complexity in the system caused by cost shifting. That is, when uninsured receive care their costs are shifted to private payers; when Medicare and Medicaid restrict rates of reimbursement those costs are shifted to private payers.

Any payment reform must, necessarily, replace volume incentives with value incentives and reduce or eliminate the perverse incentives to cost shift in the current system. Any move from fee for service needs to encourage providers to keep costs down and must be designed to hold providers accountable for both cost *and* quality of care, to help ensure that cost minimization is not achieved at the expense of quality.

What is meant by "payment reform"?

Payment policy is likely necessary to creating change in health care delivery, but not sufficient.[1] Sustainable reform will require organizational and cultural changes that can put new payment policies to good use. History has taught this lesson in its assessment of the experience with capitation, and its failure to engender broad-based transformation of the health care system.

This paper attempts to provide a very basic introduction to various options for payment reform. The reader should bear in mind the lessons provided by decades of attempts to reform the US health care system, and view these options not in a vacuum, but in the context of many related reforms that may be made. This is an important point – payment reform is but one strategy in the effort to reform the health care system. It will be critical that there is consensus around the goals for comprehensive reform – those goals should drive the various "components" used to build the framework for the renewed system.

It is also critical to recognize that seeking change solely on the supply side of the health care equation or to the intermediaries' – the insurers' – roles or environment will ensure meaningful or sustainable reform. The role of the consumer must also be the focus of attention. Consumers must become constructively engaged in their health care. Constructive engagement does not mean demanding the latest technology or the newest brand name biologic when it is not indicated or necessary. It does mean becoming an active participant in decision making around treatment options, working collaboratively

[1] Kahn III CN. Payment Reform Alone Will Not Transform Health Care Delivery. *Health Affairs.* 28(2):w216-w218. 2009.

with their providers. Ensuring consumers have access to clear, understandable, accurate and balanced information regarding treatment choices and outcomes is a vital aspect of engaging them in shared decision making which, in turn, has been shown to improve patient outcomes, satisfaction and more appropriate costs of care.

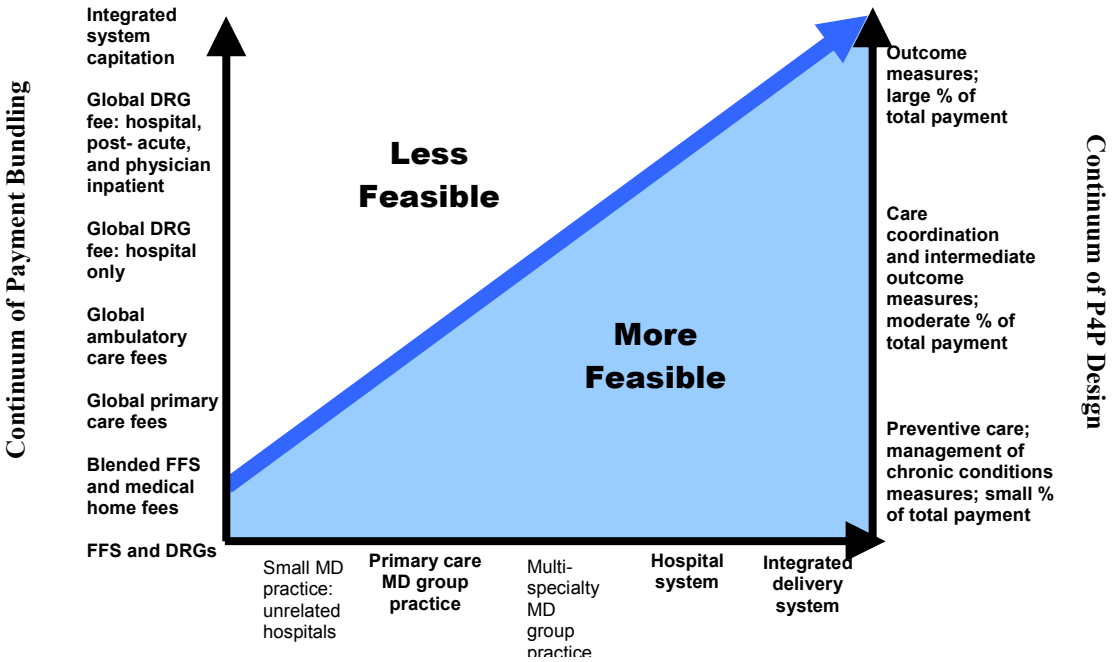
Benefit design is another tool that may be used to influence consumer behavior. The use of copayments and deductibles have long been used in this manner, encouraging the use of certain types of services (e.g. encouraging the use of preventive care by exempting those services from deductibles and copayments) and discouraging the use of others (e.g. application of high copayments to emergency department services). The tiering of benefits is a variant of benefit design that is experiencing more frequent use. Use of preferred providers – not only those participating in an insurer's network, but those meeting certain quality standards – may be encouraged by the application of lower cost sharing barriers for consumers.

Many believe that it is important that consumers bear some meaningful responsibility for their own health status. People who fail to comply with a disease management regimen may generate higher health care claims than those who do comply. For example, a person with diabetes who fails to adhere to a recommended diet is likely to experience more severe – and costly – health consequences than a similar patient who is able to adhere to prescribed nutritional recommendations. While a provider can certainly exercise an option to "fire" a noncompliant patient, some would advocate that the first patient should bear a greater portion of the cost of care, since they failed to follow the doctor's recommendations. That is an easy answer, but the root cause of that failure may be out of that patient's control (adhering to a healthful diet does cost more, perhaps the patient lacks the financial resources to always eat well). Failure to comply with laws that are designed to protect health (e.g. wearing of motorcycle helmets or seatbelts) that result in injury and costly medical care also impacts the rest of the community in terms of cost. Some would advocate that such behavior have a direct financial consequence in terms of responsibility for any resulting health care costs. This may seem to be a sensible approach, but one that also raises serious ethical and moral questions, and one worth serious discussion within our society. These are important questions with substantial implications for health reform, but they are beyond the scope of this paper.

The bedrock of current payment policy is most certainly the fee for service (FFS) approach. FFS pays for units of service, without regard to whether those services are warranted, effective or of high quality. Health care providers respond appropriately to the incentives posed by FFS and strive to deliver more units of care. FFS financially penalizes providers who work to minimize the provision of unnecessary care or who strive to deliver the least intensive type of care appropriate to a given patient's condition. Doing so translates to smaller profit margins.[2] The market incentives provided by FFS are powerful and have proven very difficult to overcome. Moving away from straight-forward FFS is the type of payment reform addressed in this paper.

[2] Mechanic RE and Altman SH. Payment Reform Options: Episode Payment Is A Good Place To Start. *Health Affairs.* 28(2): w262-w271. 2009.

There are varying degrees of change that may be considered when assessing options for payment reform. These run on a continuum from "tweaking" or recalibrating FFS payments, to pay-for-performance to bundled payments for episodes of care to global payments.[3] The relative degree of difficulty in implementing and sustaining any of these options varies. Shih and colleagues prepared a graphic representation of this situation, reproduced below.[4]



The chart nicely captures the interplay of the various elements of payment reform and the relative difficulty of their implementation. FFS – the prevailing payment method – serves as the baseline and change is met with increasing challenge, the further away from FFS the change is.

The basic variants of payment reform described here include episode of care or bundled payment approaches – including PROMETHEUS, as well as global payment approaches. Certain organizational approaches that integrate payment reforms are also discussed, including Accountable Care Organizations, and systems approaches including the Mayo Clinic model, Geisinger, Intermountain Health Care and Kaiser Permanente.

Finally, since Medicare will most likely serve as a change agent for payment reform – a role it has assumed in the past – activities underway at the Centers for Medicare and Medicaid Services are briefly described. It should be noted that most Medicaid programs

[3] *ibid*
[4] Shih A, David K, Schoenbaum S, Gauthier A, McCarthy D. Organizing the US Health Care Delivery System for High Performance. The Commonwealth Fund. New York. August 2008.

are using some variation of payment reform in their programs,[5] but those activities are so varied that it falls beyond the scope of this paper to review them.

Accountable Care Organizations

Accountable Care Organizations (ACOs) are groups of providers who come together in a formal or contractual manner to accept responsibility for the quality and cost of health care services provided to a defined set of patients. ACO groups can include one or more hospitals, along with primary care physicians; they can also extend their reach to include specialists and other types of health professionals.

The fee for service approach to payment rewards volume and intensity of service and is ambivalent to the fragmented state of the health marketplace. If we are to find a way to create sustainable improvements in quality of care and patient outcomes we need to find strategies that are relatively comfortable for patients (in terms of change) and do not unduly threaten provider incomes. Promoting organized systems of care coupled with specific changes in the approach to paying for care is thought to be one strategy to realize those objectives.[6]

Advocates for organized systems point to marked and unwarranted geographic variation in both the use and outcomes of many types of care in this country as evidence that all is not well in our health care system. There is often too-little use of effective care, a misuse of preference-sensitive care and over use of supply sensitive care.[7]

Effective care is care that has been clinically proven to improve patient outcomes. The use of beta-blockers in patients with heart attack is an example of effective care. There are many reasons effective care may be under-utilized. Fragmentation and discontinuity contribute to the underuse of effective approaches to care, for instance.

Preference-sensitive care relates to situations where there are a range of treatment options for a particular condition. Patients commonly look to their physician to make the choice of treatment option for them. This happens for any number of reasons, not the least of which is patients having incomplete information and/or a lack of ability to understand the implications of opting for one approach over another (in terms of risks/benefits, costs and so on), especially while in the midst of what can be a stressful life event. When ceding decisions to the physician, training and experience and the physician's personal values naturally influence treatment choice. However, research has shown that treatment choice should be based on the *patient's* values and preferences; when shared decision making is

[5] Kuhmerker K and Hartman T. Pay-For-Performance in State Medicaid Programs - A Survey of State Medicaid Directors and Programs. IPRO and The Commonwealth Fund. April 2007.
[6] Wennberg JE, Brownlee S, Fisher ES, Skinner JS, Weinstein JN. An Agenda for Change – Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration. The Dartmouth Institute for Health Policy & Clinical Practice. Dartmouth College. December 2008.
[7] Dartmouth Atlas Project. Supply-Sensitive Care. Center for the Evaluative Clinical Sciences. Published on-line at: wwwdartmouthatlas.org/topics/supply_sensitive.pdf. January 15, 2007.

employed, patient outcomes and satisfaction are improved and variation in use rates declines.

Supply sensitive care describes rates of utilization that are driven by local capacity, such as the supply of hospital beds, diagnostic technology, specialists, and so on. In areas where more capacity resides, more care is delivered – warranted or unwarranted. And more care does not mean better care – in fact, it may lead to poorer outcomes – and it certainly means higher spending.[8] This is particularly true for patients with chronic illnesses.

It is against this backdrop that advocacy for new systems of organized care is advanced. "Accountable Care Organization" is a term coined by Elliott Fisher of Dartmouth and Mark McClellan, the former director of CMS, now at Brookings, that describes one type of organized care system. ACOs, in conjunction with certain changes in payment policies, are seen as strategies to promote improved patient outcomes and quality of care at the lowest rate of utilization and cost – in other words, as a way to maximize efficiency of care. Importantly, the ACO "platform" can function as an element of a range of payment reform options and may be paired with bundled or episode or global payment approaches. In essence, it is a tool or an enabler of payment reform, rather than payment reform in and of itself.

Fisher, et al, envision a voluntary shared savings program, where payers (specifically recommending this strategy for Medicare and its chronically ill population) would return to providers a portion of savings realized from improving the organization of care delivery and from improving the efficiency with which care is delivered. By the same token, payers may want to seriously consider the use of a penalty for over-use of certain types of resources – acute care facilities, perhaps – in the care of particular types of chronic illnesses; this approach may have the effect of driving down capacity to more appropriate levels. To the extent that fee for service remains the prevailing method of payment, however, the incentive to drive up utilization will make it difficult to constrain investment in greater capacity. (of hospital beds, ICU beds, MRIs, specialists, etc.).

Organized practices like Geisinger, Mayo, IHC, Kaiser and others are well positioned to serve as ACOs in a shared savings payment environment. The implementation of shared savings incentives may encourage these types of systems to expand within their current markets and to seek out opportunities to enter new markets. In Maine, the presence of large, provider "families" – multi-hospital networks with large affiliated medical practices – may be able to serve as a starting point for ACOs in this state.

Episode of Care Payment Systems

Bundled payments such as those made pursuant to an episode of care payment system would be paid to a group of providers to cover all of the services a particular patient requires during a defined episode of illness. The bundle of payments refers to the

[8] *op cit* at 6.

gathering up of all payments for all providers and services the patient may need for the episode. For example, if a patient required a hip replacement, the cost of the surgery, the hospital stay, prescription drugs, rehabilitation and physical therapy would all be rolled into a single, bundled, "all inclusive" rate, rather than paying separate claims for the hospital, the surgeon, the pharmacy and the various therapies. Payment rates would be prospectively determined, with a retrospective adjustment for performance outcomes realized by a provider group. For example, provider groups experiencing higher than expected rates of mortality, given the severity and risk of their patient populations, would experience a reduction in payment rate.[9]

Episode rates would vary based on diagnosis and other patient factors, but would not be increased to compensate providers for care required for treatment related to preventable events, putting the providers at risk for the spectrum of care required by a patient for a given episode of illness. Episode rates would be developed for acute care and may be used for the payment of bundles of services for chronic illness as well. Advocates of these systems believe this approach encourages hospitals to prevent adverse events and to ensure coordination and integration with a continuum of care to address post-acute patient care needs. Episode rates also help move physicians and other providers away from the incentive to increase units and intensity of care. Combined with "facilitated consumerism" incentives (e.g. providing quality and cost data to consumers along with financial incentives intended to steer patients toward higher quality and/or lower cost providers via higher copayments), patients would be encouraged to seek out and use high quality, lower cost providers.

Medicare has used a type of episode of care system since the early 1980s – Diagnosis Related Groups (DRGs) is a narrowly defined type of bundled rate. Although it does not roll in physician payments into the payment rate, the adoption of DRGs – and later, APGs or Ambulatory Patient Groups – represents a fundamental shift away from fee for service payment. Importantly, though, these payment systems have not resulted in a decline in volume of discharges or visits. At their core, they still rely on a type of per unit payment – albeit a larger unit of service than used in fee for service - thus doing little to mitigate increases in the number of units provided.

In the 1990s, Medicare took this evolution one step further and tested a comprehensive bundled rate at seven sites, as part of its Heart Bypass Center Demonstration.[10] The demonstration's purpose was to test the feasibility and effectiveness of a bundled payment mechanism for CABG (coronary artery bypass graft) surgery, while ensuring maintenance of high quality care. The payment bundled both the hospital and physician payments into a single rate; an evaluation found no evidence of negative impact on patient health. At the same time, length of stay declined and cost of care fell.

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[9] Miller HD. *From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs.* Network for Regional Healthcare Improvement. January 2009.

[10] http://www.cms.hhs.gov/demoprojectsevalrpts/MD/ItemDetail.asp?ItemID=CMS063472

Medicare's Acute Care Episode or ACE demonstration is also exploring episode-based rates for cardiac care and orthopedic care. That demonstration is described later in this paper.

Geisinger Health System of Pennsylvania also offers a "warranty" of sorts for certain types of procedures (including CABG) that covers any additional care for preventable complications experienced by a patient within a 90-day period following surgery. This program – called ProvenCare –discussed later in this paper, is a form of episode of care payment, but will only be sited in Texas, Oklahoma, New Mexico and Colorado, per the demonstration's enabling legislation.

There are many examples of this type of integrated, warranty approach to care. The Maine Heart Center is a local hospital/physician collaborative that provides comprehensive cardiac care; payers make global payments for care provided. The Center provides additional care at no charge during a 30-day window following cardiac surgery or interventional or diagnostic cardiac procedures, should such care be required.

Episode payment rates have their own challenges. Mechanisms to parse payments out over the range of providers covered by the payment bundle need to be developed and administered. Appropriate payment rates must be developed and provider groups willing to accept this type of risk must be identified. The development of ACOs would facilitate the implementation of episode of care payment bundles.

A variation on the episode of care theme is the PROMETHEUS payment system, which is also designed to provide a bundled payment for all of the care a given patient may require for an episode of illness. The objective of PROMETHEUS is to pay the right amount to the right providers for the right care, based on the best clinical evidence available. At the same time, this approach strives to reduce administrative complexity for plans and for providers, while providing a patient-centric, quality oriented environment.[11]

PROMETHEUS will address both acute and chronic illness conditions, making it a more comprehensive system. Additionally, PROMETHEUS does not require providers to have a formal legal or financial relationship with one another in order to participate in the payment system, it requires only clinical integration.[12] Payment rates referred to as evidence-informed case rates or ECRs, are predicated on evidence based clinical guidelines, representing the best science available for the care of basic underlying conditions. Each ECR is adjusted by patient severity, for comorbidities and complications. ECRs recognize some level of variation in practice patterns in the region in which service is being delivered and include an allowance for the cost of potentially avoidable complications. Importantly, this allowance is limited to half of the current rate of "defect" or cost of potentially avoidable complications. This effectively transfers part of the risk for such complications to the hands of the provider, enhancing provider

[11] Gosfield, AG. PROMETHEUS Payment: Better Quality and a Better Business Case. *Journal of the National Comprehensive Cancer Network.* 4(10): 968-970. November 2006.
[12] de Brantes F. Theory, Results and Implementation. PROMETHEUS Payment Inc. Presented at NHRI Summit. July 31, 2008.

accountability and creating incentives to improve care processes and outcomes.[13] This allowance for potentially avoidable complications is one area where providers and payers alike may realize savings – if complication rates are reduced as a consequence of improved quality of care, all parties will experience savings. The insurer or payer assumes insurance or probability risk, while the provider assumes risk associated with the technical aspects of care delivery. Each ECR also includes a provision for provider margin, recognizing that provider organizations require return on capital assets and have a need to invest in their businesses to maintain going concerns.[14]

Whether or not a provider receives the full ECR payment is determined by that provider's performance against a performance scorecard. The scorecard assesses the deliver of critical elements of the underlying clinical guidelines for the condition involved, the outcomes of care and the patient's perception or satisfaction with the care delivered. Actual payments are not only dependent upon a specific provider's performance, but on the performance of other providers involved in the patient's care. This strategy is meant to encourage care coordination and clinical collaboration – everyone will benefit when everyone performs well.[15]

At present, acute medical ECRs have been developed for acute myocardial infarction and CABG. Inpatient procedural ECRs in place include hip replacement, knee replacement, hernia repair, coronary revascularization heart catheterization and bariatric surgery.[16] Development of certain outpatient procedural ECRs is slated for 2009.[17]

ECRs have also been developed for certain chronic conditions including diabetes, congestive heart failure, chronic obstructive pulmonary disease, asthma, coronary artery disease and hypertension. Under PROMETHEUS, ECRs for chronic illness are paid for care of the patient for the underlying condition for a given period of time; in this respect, the chronic care ECR is akin to the bundled or capitation payments discussed earlier. In addition to the design features of ECRs described above, chronic care ECRs include an allowance for "undercare" – that is, the payment rate recognizes that in the case of many chronic illnesses, there may have been underutilization of effective care. The addition of an allowance explicitly recognizing this fact (and tying final payment to the provision of such care) is intended to encourage delivery of those clinically relevant services.

Under the PROMETHEUS system, providers are not required to form legally organized networks or aggregations. The system is designed to work with solo practitioners, hospitals, multi-specialty groups, free standing diagnostic centers or fully-integrated systems – the entire gamut of providers. No single entity is charged with receiving the

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[13] *ibid*
[14] Evidence-Informed Case Rates: Construction of a New Health Care Payment Model – Playbook Version 1.0. PROMETHEUS Payment, Inc. 2008.
[15] *op cit* at 11.
[16] Gosfield, AG. Making PROMETHEUS Payment Rates Real: Ya' Gotta Start Somewhere. PROMETHEUS Payment, Inc. June 2008. Published on line at: http://www.prometheuspayment.org/publications/index.htm
[17] PROMETHEUS Newsletter, Issue 1. PROMETHEUS Inc. Published on line at: http://www.prometheuspayment.org/news-events/newsletters/2008/prometheus2008issue1.pdf

ECR payment and then parsing it out to the providers involved in a given patient's care; no Accountable Care Organization is required. The parsing of payments is carried out by the payer, based on submitted claims forms, which form a record of which provider has delivered which aspects of the evidence-based care required by the patient.

At present, the PROMETHEUS model is being piloted in a handful of sites: Rockford, Illinois where PROMETHEUS, Inc is working with the Employers Coalition on Health, and Minnesota, where PROMETHEUS, Inc is working with Medica and with HealthPartners, a large, regional health plan and multi-specialty delivery system. Work is underway in Utah, where a statewide collaboration with Utah Chartered Value Exchange is examining options for design and implementation of innovative payment reform is in progress.[18] It is too early to know what impact this approach to payment reform will have on quality of care, the cost of care or local markets.

Global Payment Systems

Global payment represents a higher degree of bundling of payments than do episode-level bundles or case rates. They are prospectively paid, fixed dollar payments for the care provided to patients over a set period of time. They place providers at risk for both the occurrence of medical conditions as well as provider management of those conditions.[19] Global payment bundles services at the patient level, as opposed to the episode level, thus their broader reach. They are meant to contain costs, encourage the integration and coordination of service, to yield the delivery of more efficient care.

Global payments are not a new phenomenon – capitation payments are a form of global payment – but the form of the global payment can vary from one area to the next. Kaiser Permanente has used global payments for many, many years and other health plans commonly utilize some type of risk-sharing arrangement with providers. Evidence regarding the effectiveness of capitation payments is mixed. It is notable that the popularity of global capitation payments peaked in the 1980s and began a decline in the 1990s.

But global payments are once again in the spotlight, as Commonwealth of Massachusetts considers adoption of global payments for its statewide payment system as part of its health reform initiative. In July 2009, the Special Commission on the Health Payment System recommended the widespread adoption of global payment, identifying it as having several important advantages of alternative forms of payment.[20] The Commission cited global payments' ability to incentivize efficiency in service delivery of a full range of services highly desirable, as are its emphasis on primary care and medical homes. The

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[18] http://www.prometheuspayment.org/

[19] Mathematica, Inc. Summary: Global Payment. Published on line; http://www.massmed.org/AM/Template.cfm?Section=Home6&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=28346.

[20] Kirwan LA and Iselin S, co-chairs. Recommendations of the Special Commission on the Health Care Payment System. Commonwealth of Massachusetts. July 19, 2009.

Commission views global payments as amenable to the use of complementary strategies including P4P, to inject additional incentives for boosting quality performance.

The vision for global payment in Massachusetts incorporates an expectation that the development of comprehensive ACOs will be encouraged and pursued. ACOs will share risk with both private and public payers; appropriate, standardized risk adjustment will ensure that the payers retain insurance risk while providers assume performance risk. Risk adjustment will incorporate current health status as well as socioeconomic adjustments. Consumers will assume an active role, facilitated by cost and quality transparency. These characteristics make global payment particularly suitable to the Commission's vision for payment reform in Massachusetts.

At present, Blue Cross Blue Shield of Massachusetts is piloting a global payment mechanism named the "alternative quality contract." The "contract" employs global, health status adjusted payment for all medical services, a highly integrated continuum of care (via ACOs) and accountability for provider performance (using P4P). Global payment rates are adjusted annually for inflation using the CPI; this means that providers realizing savings will not be penalized by cutting rates in the future and, simultaneously, will limit growth to that of the CPI.[21] The arrangement, in BCBSMA's view, offers substantial upside earnings potential through a shared savings arrangement for participating providers.[22] Participating providers are eligible for performance incentives on top of the global payment rate of between 2 and 10% if their clinical performance meets certain threshold measures. These measures are predicated on nationally accepted metrics founded on empirical evidence.[23]

BCBS of Massachusetts first introduced this new product in early 2008, but the first provider contracts for the program were not signed until January 2009. The first providers to agree to the 5-year Alternative Quality Contracts include Tufts Medical Center and its affiliate, the New England Quality Alliance, Mount Auburn Hospital and the Mount Auburn Cambridge Independent Practice Association and Hampden County Physician Associates.[24] In late July, Atrius Health – the largest Independent Practice Association in the state – signed on to the AQC program.[25] The AQC now has more than 2,000 participating physicians and covers more than 210,000 BCBSMA HMO enrollees; BCBSMA projects that, within the next several years, 15-20% of its network providers

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[21] Terry K. "Global Capitation - It's Baaaack…" Physicians Practice. Published on line: www.physicianspractice.com/index/fuseaction/articles.details/articleID/1313.htm.

[22] Gilligan P and Gelb Safran D. Alternative Quality Contract: Addressing the Twin Goals of Improving Health Care Quality While Reducing Spending Growth." Blue Cross Blue Shield of Massachusetts. March 13, 2009. Published on line: www.ma.gov/Eeohhs2/docs/dhcfp/pc/2009_03_13_Global_Payment_Alternative_Gilligan.ppt.

[23] Blue Cross Blue Shield of Massachusetts. The Alternative QUALITY Contract. February 2008. Published on line. http://www.hanleytrust.org/leadership/reading/2008/QualityContract.pdf.

[24] http://www.reuters.com/article/pressRelease/idUS137472+14-Jan-2009+BW20090114

[25] Bio-Medicine. "Two Leaders in Massachusetts healthcare collaborate to transform delivery of care." Published on line. http://www.bio-medicine.org/medicine-news-1/Blue-Cross-Blue-Shield-of-Massachusetts-and-Atrius-Health-Sign-Alternative-Quality-Contract--52114-1/ PRWeb. July 20, 2009.

will enroll in the AQC program. At this point in time, it is too early to assess any impact the initiative might have on quality or cost of care.

While attracting a lot of attention, the global payment approach has important inherent challenges. The development of credible and effective risk adjustment models has long plagued advocates of capitation payments; such a model is a critical aspect of the successful implementation of alternative quality contracts and global payment. That is, a global rate must reflect the severity of illness of patients' served. An ACO with healthy members will have lower costs than one with sicker patients and that difference must be measured and reflected in rates. A flat rate to both would disadvantage the entity with sicker patients. Similarly, convincing providers to participate in such a risk-sharing arrangement can be difficult. Managed care incorporating substantial risk sharing has been limited in Maine. This may be attributable to a historical trend of small practice organizations and lack of ACOs in the state. While larger, more integrated networks are developing here, the move to risk sharing with them is yet to be tested.

Systems Approaches

The Mayo Clinic has its roots in the late 1800's in rural Rochester, Minnesota, where Dr. William Mayo first established a solo practice. Upon their graduation from medical school in the 1880s, Dr. Mayo's sons joined him in practice. They practiced a style of medicine predicated on dedication to their patients, an approach that attracted both patients and an outstanding reputation. Over time, the Mayos invited other physicians to join them in practice and formed the first integrated, multi-specialty group practice in the country.[26]

Today, Mayo Clinic has major centers in Minnesota, Florida and Arizona. Although it is now a multi-billion dollar, physician/hospital operation (albeit a non-profit corporation), it has learned to successfully balance its historical patient-centric ethos, with cutting edge technology and medicine. With the Mayo culture at the forefront, the organization seeks out and hires staff who are interested in, respect and honor the traditions of patient dedication, teamwork and quality of care that form the foundation of the Mayo model. Physicians are employees of the organization, with salaries capped after five years.[27] The salaried employee model is intended to allow medical staff the freedom to focus on patient care rather than volume of care. Its reliance on a team approach to care allows it to identify and implement efficiencies in care delivery while practicing continuous quality improvement. That is not to say, though, that Mayo Clinic is an inexpensive source of care. Some Minnesota health plans reportedly do not reimburse as much for patients using Mayo Clinic due to its high prices. Patients from around the globe seek care at Mayo Clinic, but its prices can put it out of reach for many.[28]

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[26] http://www.diavlos.gr/orto96/ortowww/historym.htm
[27] Lee A. "How to Build a Lasting Brand." Published online. http://www.fastcompany.com/articles/2008/09/mayo-clinic.html. Fast Company.
[28] Benson L. "Mayo Clinic hopes to spread model of medical efficiency." Minnesota Public Radio. July 5, 2009.

While Mayo Clinic is a leading example of how a tightly integrated practice with salaried professional staff provides world-class quality care, it is not a payment system.

Geisinger Health Systems in northeastern Pennsylvania was founded in the early 1900s and modeled after the already-famous Mayo Clinic. Today it is a physician-led, multi-specialty, $2 billion per year, integrated health delivery system serving a population base of 2.6 million people. Geisinger employs more than 700 physicians – including 200 primary care physicians – who practice at 50 clinical sites. These sites include community clinics and three major specialty care sites. The system owns three hospitals, one of which is staffed exclusively by Geisinger physicians; both Geisinger and non-Geisinger doctors staff the other two facilities. The system also boasts ambulatory surgicenters, specialty hospitals and an in- and outpatient alcohol/drug treatment facility.[29]

Geisinger utilizes many of the tools that are considered to be vital to an efficient, effective health delivery system. These include an advanced electronic health record, patient access to health information and email with clinical staff, cross-disciplinary teams of professionals delivering evidence-based practices, as well as continuous assessment and redesign of care models. Evidence based medicine pervades the Geisinger care processes, allowing for good outcomes by design, rather than "by luck."[30] The system's history is replete with examples of how the use of evidence based protocols leads to reductions in complication rates, lengths of stay, and readmission rates.

A case in point is Geisinger's approach to elective cardiac surgery. Insurers pay a flat, all-inclusive rate for the episode of care, which extends from the point in time surgery is identified as being necessary and appropriate, through a 90-day period following the surgery. No additional charges are made for complications. When this initiative was launched, the cardiac care teams designed and implemented specific care processes built on current best practices and evidence. At the outset of the initiative, the protocols were followed 56% of the time; within a few months, that rate increased to 86% and today compliance is consistently 100%.[31] At the same time, the complication rate declined by 20%, the readmission rate by 44%, ALOS dropped by half a day *and* the hospital saved money. Geisinger uses this type of protocol model – termed ProvenCare – for a wide range of conditions, with similar results.

Geisinger has now implemented a ProvenCare approach (described earlier in this paper) for chronic disease conditions – including diabetes, congestive heart failure, and coronary artery disease.

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[29] McCarthy D, Mueller K, Wrenn J. Geisinger Health System: Achieving the Potential of System Integration Through Innovation, Leadership, Measurement, and Incentives. The Commonwealth Fund. June 2009.

[30] Legere L. "Geisinger becomes national model for better health care." Published online August 2, 2009. thetimestribune.com.
http://www.scrantontimes.com/news/geisinger_becomes_national_model_for_better_health_care

[31] *ibid.*

The Geisinger Health Plan was launched in 1985 as a network model Health Maintenance Organization. It offers group, individual and Medicare coverage. Many – but not all – of the Geisinger system's patients are members of the Geisinger Health Plan. Approximately half of the Health Plan's members use a Geisinger physician as a primary care provider, but the Plan contracts with about 18,000 independent providers (including 90 community hospitals), as well.

The Health System and the Health Plan are jointly conducting a pilot of an advanced medical home model with the objective of improving care coordination while simultaneously enhancing system accountability for the care of patients. The model has been tested in two Geisinger sites, enrolling 3,000 Medicare patients who are enrolled in the Geisinger Health Plan. The experience of this collaborative effort has been positive, with admission rates declining markedly as adherence to evidence-based care protocols increased. In all, over a 1-year period, these improvements generated a 7% savings in medical costs for the pilot population. The pilot has now been expanded to serve 25,000 health system Medicare patients who are seen at a range of system sites; enrolled patients include both managed care enrollees and fee for service patients. In the first year of the expansion, a substantial decline in admission rates for a subset of the pilot program was noted, while a control group of Medicare patients experienced an increase in inpatient utilization.[32]

The Health Plan employs disease management strategies and places nurse case managers into contracted primary care sites to deliver patient education as needed, and to promote adoption of and adherence to evidence-based practice guidelines. These strategies have allowed the Plan to realize savings of more than $100 per member per month as a result of drops in the rate of potentially avoidable hospitalizations among members with diabetes.

This super-integrated approach to delivering and paying for care has facilitated Geisinger's efforts to deliver high value care (high quality, efficient care). The availability of so many of the tools thought to be critical to the production of high value care – a multi-specialty staff insulated from incentives to increase utilization, health information technology, a partnering insurance/financing mechanism, and an ethos sympathetic to continuous innovation – sets Geisinger apart as both a delivery and payment system that may serve as a model for health care elsewhere.

Medicare and Payment Reform

The Centers for Medicare and Medicaid Services (CMS) has a vision for the United States of patient-centered, high quality health care delivered efficiently. More succinctly stated, they have set as a goal "the right care for every person every time."[33] Recognizing the considerable influence Medicare policy exerts on the health care system, generally,

[32] *op cit* at 29.
[33] Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program. Centers for Medicare and Medicaid Services. USDHHS. December 2008.

CMS is working to evolve from a volume-based payer playing a relatively passive role in the health care system to a highly activated player in the effort to move toward what it is termed as "value based purchasing" or VBP, aggressively moving an agenda of the transformation of its payment system to one predicated on the quality and efficiency of services provided, rather than one anchored to the volume of care delivered. Medicare has always assumed a leadership role in exploring new methods of payment. The shift to the Prospective Payment System and diagnosis related groups for inpatient services in the early 1980s paved the way for many other payers to begin a move toward more bundled payments. This initiative was followed by Medicare's implementation of ambulatory patient groups for payment of hospital outpatient care. Over time, though, the limitations of DRGs have become apparent; while a good step beyond fee for service, DRGs and APGs still do little to discourage admissions or visits, or to aggressively promote the provision of highest quality of care. Thus this most current effort by CMS to push the envelope once again.

In assessing its readiness for this transformation, CMS recognized that its historical culture of fee for service payment that is driven by quantity and consumption fails to support this new vision. The program established a set of goals that form the framework supporting the transition to a value-based payer and has established an agenda and set of activities focused on changes Medicare needs to implement to realize its vision. Each have been deemed integral to an underlying principle of value based purchasing (VBP), which is that the creation of appropriate incentives can encourage all health care providers to deliver higher quality care at a lower total cost.

These goals include:

- financial viability; incentives that link payment to the value of the care provided;
- joint accountability of providers and physicians;
- evidence-based, outcomes driven, effective care;
- assured access to care; safety and transparency;
- smooth transitions between phases and sites of care; and
- the use of electronic medical records and complementary health information technology to assist in implementing a value-based care system.

CMS is currently undertaking a wide range of demonstration and pilot projects designed to support its transition to VBP, which complement the goals listed above; note that at present, in most cases, solicitation periods are closed. Descriptions of these efforts, along with fact sheets, statutory authorities, status reports and so on, may be easily accessed at the Centers' website: http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp. Following is a brief summary of a subset of these activities.

- *Identify and Promote the Use of Quality Measures through Pay for Reporting*
  - The Hospital Inpatient Payment System Pay for Reporting Program is a national voluntary reporting initiative which began in July 2003. This program evolved into Hospital Compare, which was launched in April 2005. Hospitals are encouraged to submit data to CMS on a defined set of quality indicators.

While participation is voluntary, hospitals choosing to forgo participation realize a reduction in their payment update. All of Maine's acute care hospitals participate in this program and interested persons are able to view and compare reported data by visiting www.hospitalcompare.hhs.gov. Although the data reported are based on the experience of patients covered by the Medicare program, it may be informative to other consumers, as well.

- The Physician Quality Reporting initiative, authorized in 2006 is a quality reporting system for health professionals. The program includes incentive payments for satisfactory reporting compliance. Although the program has recently received permanent authorization, incentive payments are only authorized to run through federal fiscal year 2010. In 2009, incentive payments for qualifying physicians equal 2% of total allowed professional charges for the year. There is no website publicly reporting the data collected as part of this effort.
- The Home Health Pay for Reporting Program was authorized in 2005. The program provides for an adjustment to the Medicare home health market basket percentage update if quality data reporting standards are satisfied; if a home health agency fails to report the required quality data, its updating percentage will be reduced by 2%. CMS currently posts quality data for home health on the Medicare Home Health Compare website – www.medicare.gov/HHCompare.

- *Paying for Quality Performance*
  - The Premier Hospital Pay for Performance Demonstration began in October 2003. This large demonstration involves 250 hospitals in 38 states (although none in Maine) and provides bonus incentives for measurable improvements in quality of inpatient care in five clinical areas: acute myocardial infarction, pneumonia, heart failure, CABG and hip/knee replacement. Most recently, surgical care has been added to this list. In the first three years of implementation, substantial improvements in quality of care in all covered areas have been documented.

- *Develop and Use Measures of Physician and Provider Resource Use*
  - CMS has a variety of committees working to define quality measures, to develop tools and efficiency standards that may be used for this purpose.
  - The Physician Group Practice Demonstration was Medicare's first pay for performance initiative. It is designed to encourage the coordination of Part A and Part B services and to promote efficiency through improvements in administrative structures and processes by rewarding improvements in patient outcomes. This demonstration has been operating in ten large group practices across the country since April 2005. The project utilizes a calculation of per capita resource use to assess if improvements in care management have resulted in savings to Medicare.
  - The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 requires CMS to implement a program to provide confidential reporting feedback to physicians regarding their use of resources. This program has yet

to be implemented, but descriptions of the initiative are reminiscent of quality improvement efforts undertaken by the Maine Medical Assessment Foundation. Current plans for Phase I of the project will involve feedback to individual physicians in a handful of regions on a select group of conditions, using an episode of care grouper. Relatively little detailed information is available about this effort, as it is still in its very early stages.

- *Pay for Value by Promoting Efficiency*
  - These efforts represent a concerted effort to move beyond pay for reporting to pay for performance.
  - CMS has adopted a policy of non-payment for care related to reasonably preventable hospital-acquired conditions. This policy is intended to provide incentives to reduce the level of iatrogenic events. In response to a 2005 directive from Congress, CMS has disallowed incremental payments under the DRG system related to eight secondary conditions judged to be preventable complications of medical care. These conditions – or "never" events – include instances where an object is left in a patient during surgery; falls from bed; mediastinitis following CABG; blood incompatibility; catheter associated urinary tract infection; air embolism; pressure ulcers; and vascular catheter associated infection.[34] In short, hospitals stand to see considerable reductions in payments if they fail to prevent the conditions listed above. This new rule went into effect at the outset federal fiscal year 2009 for all hospitals participating in the Medicare program. There is some question, though, as to the practical effect the new rule will have, as Medicare will continue to make certain outlier payments in situations where costs substantially exceed the DRG rate and cases involving many complications may still result in the discharge being classified as a more heavily weighted, highly compensated DRG. Still, this shift does convey an important signal of Medicare's intent to reform the manner in which it pays hospitals, pushing for performance-based reimbursement.
  - Medicare will transition to a bundled payment for End Stage Renal Disease (ESRD) care in 2011. The payment will incorporate incentives for quality improvements.
  - The Medical Home Demonstration is a 3-year project authorized by the Tax Relief and Healthcare Act of 2006. While not slated to go live until 2010, it will be implemented in 8 states with the objective of promoting targeted, accessible, continuous and coordinated care to individuals with chronic or prolonged illness. Participating practices will be required to provide regular medical monitoring, advising and treatment of the targeted group of beneficiaries. The program will pay a care management fee to two tiers of medical home practices, basic and advanced. Monthly fees will range from $27.12 for low severity patients in Tier One practices to $100.35 for complex patients in Tier Two practices. Enrollment in an estimated 400 practices (2000 physicians) is expected to begin in January 2010.

[34] Rosenthal MB. Nonpayment for Performance? Medicare's New Reimbursement Rule. *The New England Journal of Medicine.* 357(16): 1573-1575. October 18, 2007.

- *Promote Alignment of Financial Incentives Among Providers to Realize Joint Financial and Clinical Accountability*
  - CMS has a number of "gain sharing" demonstrations designed to promote joint accountability. Importantly, CMS has been given statutory authority to allow gain sharing in limited circumstances; the practice of hospitals financially rewarding physicians for taking actions to lower the cost of care provided to patients (thereby generating "savings" to the hospital under the DRG payment system) is otherwise prohibited. These demonstrations will allow a sharing of savings arising solely from collaborative efforts to improve quality and efficiency of care.
  - The Physician Hospital Collaborative Demonstration ("Section 646") was authorized by the Medicare Modernization Act and is designed to examine factors that support improvements in the quality of care and specifically investigating the effectiveness gain sharing may have on stimulating improvements in quality of care. This project incorporates long term follow up to ensure the durability of quality improvements and continued reductions in costs of care. This 3-year project began in July 2009; it is being conducted by a consortium consisting of 12 hospitals across the state and the New Jersey Care Consortium, administered by the New Jersey Hospital Association.
  - The Acute Care Episode Demonstration (ACE) will test the use of a bundled payment for both hospital and physician services for a select set of inpatient episodes at five "value based centers" in Oklahoma, New Mexico and Colorado. Bundled payments will be made for 28 cardiac and 9 orthopedic inpatient elective services. All targeted services have historically high volumes, all are easily defined and are subject to a competitive marketplace and extant quality metrics exist for each. The project will also test the effect that transparency in price and quality information has on beneficiary behavior.
  - The Post Acute Care Payment Reform Demonstration was authorized by the Deficit Reduction Act of 2005. The DRA mandated that a standardized patient assessment be conducted at the point they are discharged from hospital, without regard to the site of care where they might receive post-discharge care (if any). This requirement was designed to provide comparative data regarding post-acute care across sites of care, for use in reforming payment for such care. The data will also be used to examine and gain insight into differences in treatment and outcomes of post-acute care. This initiative was implemented in 2007 and entered a second phase in January 2008, in 10 market areas (Phase One focused on the development of standardized assessment tools). In March 2008, the effort expands to include 9 additional markets; the demonstration is slated to run through 2009, after which evaluation and findings will be collated and published.

- *Foster Transparency and Public Reporting*
  - Initiatives related to this focus area include the "Compare" websites for hospitals, nursing facilities, home health agencies and ESRD providers.

- Chartered Value Exchanges are communities identified by USDHHS as actively striving to improve quality and value. These communities participate in a range of activities aimed at facilitating improvement in value, including Learning Networks sponsored by the Agency for Health Research and Quality. The Maine Quality Forum, the Maine Health Management Coalition, Quality Counts and Health InfoNet are members of the Maine CVE alliance.

- *Encourage the implementation of Electronic Medical Records and HIT*
  - CMS is instituting an e-Prescribing incentive program in 2009; the program is currently slated to run through calendar year 2013. This program will provide a bonus incentive to physicians and professionals who meet specific criteria for reporting on an e-prescribing quality measure for Part D prescription orders. Qualifying providers will be eligible for incentive payments equal to 2% of their allowed professional charges in 2009-2010. This payment declines to 1% for 2011-2012, and to 0.5% in 2013.[35] Similarly, providers failing to adhere to the prescribing standards will realize financial penalties equal to 1% in 2012, 1.5% in 2013 and 2% in 2014 and beyond.
  - CMS had been working to implement a 5-year Electronic Health Record demonstration designed to encourage small and medium sized primary care practices to use EHRs to improve quality of care and outcomes. It was to provide financial incentives to approximately 1200 practices using certified EHRs, who demonstrated improved quality of care as measured by a set of prescribed clinical quality measures. In the first year, a practice was able to earn up to $5,000 per physician or $25,000 per practice in incentive payments. Maine was to be included in Phase II of the demonstration, but the demonstration has now been cancelled as a result of enactment of the HITECH Act provisions (Health Information Technology for Economic and Clinical Health Act) which was enacted as part of the American Recovery and Reinvestment Act of 2009. The provisions of HITECH lay out a roadmap for a national health information infrastructure and provides for enhanced reimbursement for the (as yet to be defined) meaningful use of EHRs.
  - The Personal Health Record Pilot program will provide Medicare beneficiaries in Arizona and Utah with access to an electronic version of their medical record. This project is set to launch in 2009.

Next Steps

The cost and complexity of the health care system, funded by multiple payers with often different requirements, result in inefficiencies that drive costs higher. To affect change requires a more "systems" approach to delivery of care and significant and consistent changes across all payers that change incentives to reward value not volume. Maine has laid a foundation to take the next steps in payment reform

[35] http://www.cms.hhs.gov/pqri/downloads/pqrieprescribingfactsheet.pdf

Maine's health providers have a history of cooperation. The State Health Plan, which guides the certificate of need program, and the Hospital Cooperation Act incentivize collaboration to reduce redundancy and improve efficiency. The Maine Health Management Coalition, an employer group that for 15 years has convened payers and providers to advance reform, is launching a payment reform demonstration. MaineCare, Maine's Medicaid program will soon restructure its payment policies to incorporate DRGs and APGS much as Medicare does. The State Employees Health Plan has been a leader in tiering benefits, creating incentives to select high quality providers. Recently, a collaboration of organizations has launched the Patient Centered Medical Home (PCMH) demonstration in 26 varied practice sites statewide and Martin's Point has launched its own PCMH initiative. The Advisory Council on Health Systems Development, (ACHSD) with its research partners, has documented considerable variation in care that drives potentially avoidable costs

From this base, Maine is well positioned to make meaningful payment and systems reforms. Those reforms will be best achieved in collaboration across all parties – employers, government, health plans, consumers and providers-and would greatly benefit from a partnership with the federal government and its Medicare program

The Maine legislature enacted a law last session calling on the ACHSD to examine the issues in payment reform and make recommendations in January 2010 regarding what role the legislature may play to advance payment reform for Maine. This paper launches the ACHSD's work. As a multi-stakeholder group, the ACHSD intends to educate itself through a series of meetings and discussions and fully engage all the key parties in Maine, in hopes of achieving consensus recommendations .